REPORT ON THE NURSING FACILITY PERFORMANCE EVALUATION SYSTEM

EXECUTIVE SUMMARY

Under the provisions of Health General Article §19-135(d), the Maryland Health Care Commission (Commission), in consultation with the Department of Health and Mental Hygiene and the Department of Aging, must develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis and annually publish the summary findings of the evaluation. The report should be developed and implemented on or before July 1, 2001.

The purpose of the nursing facility comparative evaluation system ("nursing home report card") is to improve the quality of care provided by nursing facilities through establishing a common set of performance measures and disseminating the findings of the comparative evaluation to nursing facilities, consumers, and other interested parties.

In developing the nursing home report card, the Commission must consider the health status of the population served. The law also requires that, as appropriate, performance information be solicited from consumers and their families. The Commission has construed this requirement to mean that the Commission should explore the feasibility of collecting patient and/or family satisfaction data similar to what is collected in the Commission's HMO report card.

To assist with the development of the nursing home report card, the Commission convened the Nursing Home Report Card Steering Committee ("Steering Committee"). The Steering Committee consists of interested parties including representatives of relevant state agencies, nursing homes, academic experts in data collection issues, and consumers.

The Nursing Home Report Card Steering Committee has reviewed and discussed the key issues outlined above affecting the presentation of performance evaluation data. The Steering Committee has agreed that the nursing facility performance evaluation system should address the following items related to design and content:

<u>Design</u>

1. Information presented to the public should consist of a single performance evaluation report consisting of comprehensive care nursing home facility-level information. Continuing Care Retirement Communities (CCRCs) with comprehensive care beds will also be included in the report.

2. The primary audience for the nursing facility report is the general public residing in Maryland and surrounding states. They consist of both current and future consumers of facilities (both long-term care and sub-acute care residents) and their

families/caregivers, in addition to nursing homes, CCRCs, healthcare providers (e.g., hospitals), assisted living facilities, insurers, government entities (e.g., regulators), and the media.

3. The reports should be web-based with supplemental hard-copy brochures describing the report and ways to obtain access. Consumers will access nursing facility specific information from the web site by facility name, geographic region, and through a search capability. In addition, links to relevant web sites will enable the user to obtain additional information on selecting quality nursing facilities.

4. A consumer guide section should also be available on the website to supplement the data. The consumer guide will present the user with additional information to assist in the selection of a nursing facility including issues to consider that are not readily transferable to specific measures of quality. A nursing home checklist should be available either on the report card website or through a link to other existing checklists. A checklist is a questionnaire designed to lead the consumer through the decision making process.

Content

5. Structural, or descriptive, and process information is recommended for the initial report – facility characteristics and resident characteristics. These categories contain information determined to be useful for consumers' decision-making processes in selecting a nursing facility and monitoring the quality provided.

   Facility data characteristics will consist of facility descriptive information (e.g., ownership, beds, and fees); licensure and certifications; personnel and staffing; and clinical services (e.g., rehabilitation care, dementia care). The category "resident characteristics" will include information on the gender, age, ethnicity or language, and functional ability (e.g., percent of residents requiring feeding assistance) of the nursing facility residents.

6. Existing indicators that are valid and reliable should be included as measures of outcomes in the initial report. They would fall under the following domains:

   - Clinical
   - Psychosocial
   - Medication prescribing
   - Functional
   - Satisfaction
   - Quality of life
   - Deficiencies and complaints

   The majority of Quality Indicators (QIs) for the clinical, psychosocial, medication prescribing, and functional domains were developed by the University of Wisconsin Center for Health Services Research and Analysis (CHSRA). The CHSRA indicators

have been validated against chart review and subsequently were adopted by HCFA for national use in monitoring nursing facility performance. As required by law, nursing facilities routinely submit MDS data to the state data repository, which is then forwarded to a national repository. QIs are abstracted from the MDS data.

The Steering Committee agreed to report reliable and valid QIs based on public availability (i.e., only HCFA measures); proprietary measures will not be used. At present, there are few established measures for the satisfaction domain and none for the quality of life domain.

Nursing facility deficiency and complaint data are reported during the state survey process using the OSCAR database. Complaint data are also collected by the OHCQ and subsequently forwarded to HCFA. The Committee has agreed that valid complaint data should be presented in the report by facility as a rate adjusted for facility size, showing a trend over a three-year period. "Valid" complaints are defined as complaints that have generated a deficiency as defined by federal and state standards.

7. To assure a fair and accurate comparison among the nursing facilities, risk adjustment strategies should be employed whenever possible. While not all QIs require adjusting for patient-level risk, some indicators may necessitate risk-adjustment. This can be achieved though stratification or by regression-based methods. For example, the 'prevalence of stage one to four pressure ulcers' indicator could be adjusted by restricting the denominator to residents without ulcers during the most recent assessment. Another means of risk-adjusting the QIs is by comparing the proportion of residents observed with ulcers to the proportion expected, based on a multivariate regression model that accounts not only for the proportion of residents admitted with ulcers but also for other characteristics known to be associated with ulcers (like diabetes and lack of mobility).

8. Patient satisfaction information should not be incorporated in the nursing facility performance evaluation initially. Since nursing facilities do not use a common survey instrument, the Steering Committee concluded that more information is needed in this area. Moreover, surveys currently used by nursing facilities may be designed to address a particular facility's internal needs for quality improvement rather than for public reporting.

   Although Senate Bill 740 (1999) requires the Commission to 'solicit performance information from consumers and families,' consumer information will not be incorporated in the nursing home performance evaluation initially. Budget considerations and time constraints prevent the Commission from conducting a consumer satisfaction survey this year.

9. Because a nursing home administration or a facility's resident characteristics can change rapidly, the report should be updated more often than annually, as feasible.

10. The Maryland Nursing Home Performance Report should be an evolving document incorporating methodological advances in quality reporting over time as new measures are validated. Thus, the Nursing Home Report Card Steering Committee should continue to meet periodically to monitor the progress of report development and consider new measures that have been validated including tools to assess patient satisfaction.

I. Introduction

The Maryland Health Care Commission ("MHCC or Commission") is a 13-member independent commission located administratively within the Department of Health and Mental Hygiene ("DHMH"). The Commission is responsible for carrying out the provisions contained in Health General Article §19 sections 101 through 141. The Commission was created in 1999 by combining the Health Care Access and Cost Commission ("HCACC") and the Maryland Health Resources Planning Commission ("MHRPC").

Under the provisions of Health General Article §19-135(d), the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, must develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis and annually publish the summary findings of the evaluation. The report should be developed and implemented on or before July 1, 2001 (see Appendix A for enabling legislation).

The purpose of the nursing facility comparative evaluation system ("nursing home report card") is to improve the quality of care provided by nursing facilities through establishing a common set of performance measures and disseminating the findings of the comparative evaluation to nursing facilities, consumers, and other interested parties.

In developing the nursing home report card, the Commission must consider the health status of the population served. The law also requires that, as appropriate, performance information be solicited from consumers and their families. The Commission has construed this requirement to mean that the Commission should explore the feasibility of collecting patient and/or family satisfaction data similar to what is collected in the Commission's HMO report card.

II. Nursing Home Report Card Steering Committee

To assist with the development of the nursing home report card, the Commission convened the Nursing Home Report Card Steering Committee ("Steering Committee"). A similar steering committee was utilized by the Commission during the development of its HMO performance evaluation system. The Steering Committee consists of interested parties including representatives of relevant state agencies, nursing homes, academic experts in data collection issues, and consumers. See Appendix B for a complete listing of the Steering Committee members and their affiliations. The following is a brief summary of Steering Committee activities.

<u>September 1999</u>

The Steering Committee met for the first time on September 30th for its organizational meeting. Staff had prepared a briefing book that included an overview of nursing home related data that are currently being collected in Maryland and some background material related to nursing home performance reporting in general. In addition, the staff collected

materials from other nursing home performance reports currently being prepared by the federal government, state agencies in other states, and public/private consumer groups. Finally, staff gave a brief overview on a possible approach to the type of information that might be considered for the report card including: facility descriptive information; state agency deficiency and complaint information; clinical outcome data; and information collected from resident and/or family satisfaction surveys.

October 1999

The Steering Committee was given a presentation on the *Guide to Nursing Homes in Florida* ("*Guide*") by Mr. Jeffrey Gregg, Chief of the Office of Health Policy in the Florida Agency for Health Care Administration (AHCA). The *Guide* lists nursing homes, skilled nurse facilities, hospital-based skilled nursing facilities, and continuing care retirement communities (CCRCs) in Florida by region and county. It offers tips on selecting a nursing home and questions to ask when choosing a facility. The Guide also includes facility-specific comparative information. That comparative information includes each facility's name, address and phone number as well as its licensee's name and the ownership type (e.g., for-profit, nonprofit, government), number of licensed beds, number of rooms, the forms of payment it accepts, and any special services offered.

The *Guide* also gives each facility a "rating" which is an assessment of quality and performance at the time of the state's annual inspection. A "superior" rating means that the facility exceeds the minimum licensure standards; a "standard" rating means that the care and services meet minimum standards, and a "conditional" rating indicates that the facility has failed to meet minimum standards. In addition to the *Guide*, the Florida AHCA also publishes a quarterly *Watch List* which reflects the facilities that were given a "conditional" rating at any time during the preceding three months. The *Watch List* specifies the deficiencies that were found during an inspection and notes if the deficiencies that resulted in the rating have been corrected. Facilities appealing the state's inspection results are also noted. In addition, the *Watch List* includes the number of times that each facility has appeared in the publication.

Mr. Gregg also noted that, in 1999, the Florida legislature enacted a bill that requires the AHCA to annually conduct a consumer satisfaction survey of all nursing home and hospital skilled nursing units in the state. The residents who live in the facilities as well as their family members and guardians are to be surveyed. That Act makes participation in the survey process a condition of licensure for those nursing facilities. At the time of the presentation, the AHCA was in the process of selecting a vendor to organize and conduct the consumer satisfaction surveys.

Following the presentation on the Florida report card, staff reviewed a number of other report cards that are available from state agencies in other states and public/private consumer groups. These report cards include the California Advocates for Nursing Home Reform Consumer Information on California Nursing Facilities; the Massachusetts Survey Performance Tool for Nursing Homes; the Consumer Guide to Michigan Nursing Homes; the National Eldercare Referral Systems, LLC (www.nursinghomereports.com);

the New Jersey Performance Report for Nursing Homes; and Finding a Nursing Home in New York State (see Appendix C for examples). Most of these report cards contain facility descriptive information supplemented with information gathered through that state's nursing home inspection process. The Michigan report card included satisfaction information collected from families who have a relative in the facility.

November 1999

On November 19, the Steering Committee heard a presentation by Ms. Lynne Condon of DHMH's Office of Health Care Quality (OHCQ). Ms. Condon gave an overview of the Minimum Data Set (MDS)[1] and Quality Indicators (QIs) along with a description of how the state inspection process works. The MDS is raw data collected from nursing facilities that reflects information about its resident population. QIs are a set of indicators of quality of care in nursing homes used for internal and external quality review and improvement. The OHCQ, in its role of licensing and inspecting nursing homes, utilizes the QIs to alert its inspection surveyors to potential problems in a nursing home. Ms. Condon reviewed the advantages and disadvantages of the MDS and QIs. In addition, she described how the information is collected and how the data are utilized by the State and by the federal Health Care Financing Administration (HCFA). The Steering Committee was especially interested in the use of QIs for public reporting of comparative nursing home information.

January 2000

At the January meeting, Mr. Ed Mortimore, a representative from the HFCA, briefed the Steering Committee on the Online Survey, Certification, and Reporting (OSCAR) database which is based on information collected during a required survey conducted by the OHCQ.[2] Mr. Mortimore gave a brief history on HCFA's "Nursing Home Compare" website that contains certain facility descriptive information and describes any deficiencies that may have been found from state inspections. Some resident characteristic information is also presented. Self-reported OSCAR data reflects an aggregate measure of facility-level information as opposed to the MDS data that are collected at the resident level. The Steering Committee then had a general discussion about the interpretability of the data, the timeliness of the data's release, and issues related to distinguishing between physical problems that a resident may have at the time

[1] The MDS portion of the resident assessment instrument (RAI) captures the resident's physical and cognitive status, acute medical condition, nutritional status, and behavioral and emotional status. MDS data are used for resident care planning, to calculate the resident's casemix index for determining the payment rate under the Medicare skilled nursing facility (SNF) Prospective Payment System (PPS), and for the federal and state long term care quality monitoring system, through the generation of MDS-based quality indicators.

[2] The OSCAR data are collected as part of a state survey process to verify compliance with federal regulatory requirements for participation in Medicare and Medicaid. State agencies are required to survey each facility no less often than every 15 months. Follow-up surveys may be conducted to assure that facilities correctly identify deficiencies. Surveys are also required when there is substantial change in a facility's organization and management or as a follow-up to a complaint about substandard care.

of admission versus those problems that occur after a resident has been admitted to the facility. There is general consensus that the details of any deficiencies found during a state inspection should be included in a report card along with any plan of correction that a facility may be undertaking.

Ms. Julie Tyler of the Delmarva Foundation also briefed the Steering Committee on their role in quality improvement projects for both Medicare and Medicaid populations. Delmarva Foundation is one of five Peer Review Organizations participating with HCFA on the Skilled Nursing Facility Prospective Payment System (PPS) Quality Medical Review Pilot Project. The purpose of the pilot project is to develop a medical review process that ensures Medicare beneficiaries are provided appropriate nursing care services under PPS.

February 2000

In February, the Steering Committee was briefed by Ms. Susan Nonemaker from HCFA on the MDS-derived QIs. Researchers at the Center for Health Systems Research and Analysis (CHSRA) of the University of Wisconsin-Madison developed and tested a set of indicators of quality of care in nursing homes and a quality monitoring system for using the indicators for internal and external quality review and improvement. It is HCFA's belief that QIs are not direct measures of quality; they are pointers that indicate potential problem areas that need further review and investigation. They were developed for state surveyors to use in targeting problems and for the use of nursing facilities in conducting internal quality improvement. Ms. Nonemaker stated that HCFA is concerned with the use of QIs as measures of quality but admitted that there are political pressures for utilizing them and HCFA is moving incrementally toward the public dissemination of a limited number of QIs on its Nursing Home Compare website.

Ms. Nonemaker enumerated a number of concerns that HCFA has with making the QIs publicly available. First, there is the issue of data reliability; the MDS data can be accurate but its accuracy is dependent of the amount of training and support given to the facility personnel who collect the resident-level information. As is the case with much of the nursing home staff, there is a high degree of staff turnover at many facilities. In addition, the QIs may be reflecting the fact that some nursing facilities are treating patients with a high number of difficult problems. Proper risk adjustment is crucial so that those facilities taking those hard-to-treat cases are not penalized. Finally, there is the possibility that QIs could be misleading to the consumer.

Commission staff also briefed the Steering Committee on the Texas Department of Human Services Quality Reporting System (QRS). The QRS provides information about non-hospital nursing homes in Texas that are certified to accept Medicare or Medicaid residents. The Texas Department of Human Services cautions that it is not meant to serve as the only basis for choosing a particular facility. They recommend that consumers use the QRS to obtain specific information about a particular facility, to compare facilities, or to help identify one or more facilities to visit.

March 2000

On March 24th, Steven A. Levenson, M.D., a nationally recognized physician leader, practitioner, author, and educator in long-term and subacute care,[3] briefed the Steering Committee. Dr. Levenson gave a presentation on the quality of care in nursing facilities. He noted that many converging forces are putting pressure on nursing facilities including increased financial pressures from decreasing federal reimbursement, workforce issues due to nursing shortages and high staff turnover, changing demographics as the population ages, and increasing public expectations for high quality services in nursing homes and in the health care sector in general.

Dr. Levenson spoke about measuring and improving patient outcomes and service quality. Important factors to consider are understanding the difference between individual versus aggregate results, the time frames for assessing and reporting results, risk-adjustment issues, and a need for definitive care objectives. Nursing home resident characteristics and processes for the delivery of care are the principal factors affecting outcomes. Optimal quality service depends on the effective collective performances of individuals. Effective policies, procedures, and protocols that promote rather than inhibit desired performance, and are tied to systems and processes that enable effective performance are required to increase quality in nursing facilities.

Dr. Levenson noted that clinical data gathered from nursing homes in the form of QIs show "results," but many of those same results have different root causes. Results can not be taken at face value, leading to the need for risk-adjustment strategies. A difficulty with measuring quality in nursing homes is that many of the resident's physical problems are caused by a combination of a certain level of functional impairment, co-morbidity with other illnesses, and the illness' severity level. One of the most important issues is that many outcomes indicators look at symptoms but not at the underlying causes. For example, problems present in those with chronic conditions or those experiencing the natural deterioration of aging are not the fault of any particular care-giving process or provider.

Staff also began discussions on the need to issue a Request for Proposal (RFP) for a Nursing Home Report Card Design and Development. There was general consensus that the development of a conceptual model to facilitate decision-making by the Steering Committee would be beneficial.

[3] Subacute care is comprehensive inpatient care that is designed for someone who has an acute illness, injury, or exacerbation of a disease process whose treatment does not require to any significant degree, high technology monitoring or complex diagnostic procedures. It is generally more intensive than traditional comprehensive facility (nursing home) care and less intensive than acute care. This definition is consistent with COMAR 10.25.05 (Maryland Health Resources Planning Commission, Subacute Care Project: Preliminary Report, December 1995).

April 2000

At the April meeting, the Steering Committee was briefed by Ms. Carol Benner, Director of DHMH's OHCQ, on the six bills related to nursing homes that successfully passed the 2000 legislative session of the Maryland General Assembly. Those bills included legislation related to: (1) Sanctions and Penalties (HB 634/SB 689); (2) the Maryland Nursing Home Quality Assurance Act (HB 747/SB 690); (3) Quality of Care Oversight (HB 748/SB 698); (4) Inspections (HB 749/SB 688); (5) Staffing (HB 784/SB 794); and (6) the Ombudsman Program (HB 865/SB 764). All of these bills had their genesis in the recommendations of the Task Force on Quality of Care in Nursing Facilities, which was created by the same legislation enacted in 1999 that gave the Commission the statutory authority to develop the nursing home performance evaluation system. The Task Force had been charged with making recommendations to the General Assembly regarding changes to current standards, policies, and procedures as necessary to ensure quality of care in nursing facilities.

The Steering Committee began discussion of information related to facility descriptors. Staff prepared a chart that listed all facility characteristics that are included on performance reports from other states. The chart indicated which of these data elements are currently being collected in Maryland. Preliminary discussions reflected the idea that using currently collected information would be preferable in the short term and any additional data not currently being collected could be considered for future iterations of the performance reporting system.

May and June 2000

During the month of May, Commission staff drafted a RFP requesting vendors to make recommendations for a conceptual design for the nursing home performance report; to identify and evaluate tools for measuring nursing home performance, including any risk adjustment; and to develop a plan for implementation. The RFP was publicly issued on May 23rd. Staff briefed the Steering Committee on the RFP and the thinking behind the requested services.

In June, staff also briefed the Steering Committee on a number of issues surrounding the potential inclusion in a nursing home performance evaluation system of long term care needs currently found in Continuing Care Retirement Communities (CCRCs) (see Appendix D). There was a general consensus to include CCRCs that have comprehensive care beds. However, there was also concern that those facilities may have such small numbers of comprehensive care beds giving rise to issues surrounding data collection and confidentiality that must be balanced against the desire for presenting information inclusive of all long-term care facilities. There was a general agreement that, at a minimum, some descriptive information about CCRCs would be helpful to consumers.

Finally, staff briefed the Steering Committee on information that was gathered at the National Case-Mix Reimbursement and Quality Assurance Conference held in Madison Wisconsin at the end of May. Commission staff attended a number of panel discussions

including presentations related to the evolution of the CHSRA MDS QIs, work being done on nurse staffing as a quality of care indicator, the measurement and improvement of "quality of life" in nursing homes, research into HCFA's Nursing Home Compare website, and a number of other nursing home quality projects being undertaken in other states.

July and August 2000

While the Steering Committee did not meet during July and August, Commission staff received a number of responses to the RFP that had been issued in May. The staff reviewed those proposals, interviewed potential vendors, and selected a vendor.

The Nursing Home Performance Report Design and Development Evaluation Committee (Evaluation Committee) was comprised of three representatives of the Nursing Home Report Card Steering Committee (Frank Chase – consumer representative, Meg Johantgen – academic data expert, and Adam Kane – industry representative) and four members of the MHCC staff (John Colmers, Barbara McLean, Enrique Martinez-Vidal, and Kristin Helfer Koester). Gene Heisler, Assistant Director of DHMH's OHCQ, was also consulted.

Based on the strength of the technical proposals, the information collected from the presentations and follow-up questions, and the financial proposals, it was agreed by consensus that the overall proposal of Abt Associates, Inc. provided the most advantageous offer to the State. The Evaluation Committee unanimously considered Abt Associates to be the most qualified contractor based on Abt Associates' experience in federal and state performance of quality of care measurement systems (particularly MDS and OSCAR data); its understanding of risk-adjustment requirements; and its comprehension of the difficulties underlying patient satisfaction measures, as well as the experience and qualifications of its proposed subcontractors (Rhode Island Quality Partners, Inc. and Guild Communications). The contract with Abt Associates began September 1, 2000.

September 2000

On September 19th, Karen Reilly, Sc.D. of Abt Associates and David Gifford, MD, MPH of Rhode Island Quality Partners, gave the Steering Committee an overview of their proposal for developing a conceptual design and an implementation work plan for the nursing home performance reporting system. That proposal also includes the review of currently available evaluative tools and reporting formats for measuring nursing home performance.

October 2000

On October 2, Abt Associates delivered its first required report, "Review of Existing Nursing Home Performance Reporting Systems" (Report is available from the Commission upon request).

At the October 24th meeting, the Steering Committee began its decision making process on potential categories and domains for the public reporting of Maryland nursing home performance using a Conceptual Design Options Paper provided by Abt Associates. This options worksheet summarizes: (1) the four broad conceptual categories under which all nursing home elements should be reported (facility characteristics, resident characteristics, quality measures, and consumer decision guides); (2) aspects within each broad category to be considered for reporting (e.g., clinical services offered by a facility); and (3) specific properties of nursing facilities that may be of interest within each subcategory (e.g., whether therapy services are offered by a particular nursing facility).

The Steering Committee scrutinized each potential measure and made suggestions as to which ones Abt Associates should further investigate. There was general consensus that data not currently being collected, proprietary data, and data that had not been validated should not be considered for the July 2001 iteration of the nursing home performance report.

November 2000

Abt Associates delivered its second required report, "Review of Literature on Measuring Quality on Long Term Care" (Report is available from the Commission upon request). The Steering Committee did not meet during this month; however, they continued to review the reports.

III. Policy Issues

The design and development of the nursing facility performance evaluation system requires a comprehensive review of existing data sets and quality initiatives, samples of current reports, and knowledge of issues raised by interested parties. In addition, the Commission and the Steering Committee are concerned about policy issues affecting the development of the nursing facility performance evaluation system. These issues are classified into two separate categories – the data or “content” and the design or “form.”

The “content” of the evaluation system comprises issues related to performance measurement. These data issues include the selection of data elements, the reliability and validity of those data elements, timeliness, risk adjustment, and patient satisfaction assessment.

The “form” of the performance evaluation system encompasses issues related to the design of the system. Issues related to design focus on questions such as:

- Which facilities should be included in the performance evaluation system (i.e., continuing care retirement communities (CCRCs) and assisted living facilities)?
- How should the report be presented to the public? (i.e., web-based or hardcopy)?
- Who is the audience for performance reporting information?

The following section of this report addresses issues related to data collection and design of the evaluation system.

A. Data Issues

Selection of Quality Measures and Risk Adjustment

Thorough research and analysis is needed when selecting quality measures for a public reporting system. The information ultimately presented to the consumer must be clear, concise, and easily understandable. The Steering Committee comprehensively reviewed and discussed various data elements and their sources before recommending information that should be publicly reported to the Maryland consumer (see Appendix E for a chart of quality measures that are being recommended for inclusion).

Tools used to measure quality of care delivered by a health care facility are classified in four categories: (1) the *structure* of care reflecting the resources to deliver care (e.g., staff, equipment, facilities); (2) the *processes* of care which are the activities carried out to deliver the care (e.g., use of feeding tubes); (3) *outcomes* of care such as the incidence of falls, infection rates, and mortality rates; and (4) *patient satisfaction* with care. Indicators that measure the structure of care are indirect measures of health care quality. They are proxies for quality, which tell more about the care a patient/resident *might* receive than the care the patient/resident *actually* receives. However, if numerous studies support a correlation between an indicator and high quality care, then a general assumption about quality can be made.

The most direct measures of quality are indicators based on processes of care and outcomes. However, the utilization of outcomes-based indicators must account for differences in resident characteristics. In order to make valid comparisons of information from different nursing homes, the data must be risk-adjusted. A statistical model must take into account resident-specific variables that are beyond the control of the nursing homes. These variables could include the age of the resident, the severity of the patient's condition, other attending complications, as well as a number of demographic factors. Risk-adjustment allows for fair comparisons of the same diagnosis across all of the nursing homes because it takes into consideration pre-existing factors that could alter the outcome of care. A number of risk-adjustment models exist today, however, there is no agreement as to which one is the best. Another difficulty with risk-adjustment is that it is impossible to account for every single risk factor that may influence a particular outcome.

Quality indicators (QIs) are indicative of performance. The presentation of QIs will assist potential users of a nursing home (i.e., residents or family members) in selecting a facility. Also, QIs encourage facilities to compare their performance with the best-established practices and stimulate competition. Factors such as data collection burden, data reliability, and expense must be considered when reviewing the various options for the performance evaluation system.

Reliability and Validity

A performance evaluation system or “report card” that consists of valid and reliable data is essential to ultimate acceptance by the public. Structure and process measures are currently the most prevalent and easiest to measure; however, if using these measures as surrogates for quality, the literature must support the use of those measures. While outcomes measures are most directly related to quality of care, they may require risk adjustment. Risk adjustment entails the use of detailed medical and demographic information that is contained in a patient's medical record. In the case of nursing homes, the MDS data are patient-related and contain detailed information about a patient's demographic and medical condition. Using the MDS data for crude risk adjustment is feasible and desirable.

Independent Verification

Most of the descriptive (structure) and process data and measures (i.e., the activities carried out to deliver the care) are collected through the federal OSCAR database and the MHCC’s Long Term Care Survey (LTCS). State agencies are required to survey each facility no less often than every 15 months and report findings using the OSCAR database, whereas, representatives of Maryland nursing home facilities are required to complete the LTCS on an annual basis. Since this information is collected infrequently, the Committee may require each facility to validate the data before public dissemination. Such structural data indicate a nursing facility’s ownership, number of beds, and accreditation status. Whether a facility provides ventilator and special respiratory care, and dialysis services are examples of process measures. These measures do not require risk adjustment and may be self-reported.

Outcome data are currently collected through the federal MDS. MDS data are the leading source for QI measures. MDS data are collected into a national repository and must pass multilevel system edits, thus, many MDS data elements are regarded as reliable and valid. Examples of this type of data are "incidence of new fractures," "prevalence of pressure ulcers," and "prevalence of bladder or bowel incontinence."

Timeliness

The Steering Committee, along with the MHCC, is committed to providing the consumer with accurate and up-to-date information. Many of the data elements that will be presented in the nursing facility performance evaluation systems are subject to change; therefore, it is imperative to maintain a method of dissemination that enables the MHCC to update the data on an ongoing basis. The medium selected should allow the MHCC to frequently access the data and make any updates deemed necessary.

Data Sources

Numerous studies identify ongoing issues with the validity of data sources. Most administrative health care databases were designed for financial purposes and not clinical

purposes. However, they currently are widely used for quality assessment because of the low cost of data collection and universal availability. Clinical data, mostly found in medical records, are more accurate and comprehensive. Patient satisfaction surveys are another source of data; however, they are costly to administer.

As previously mentioned, the OSCAR data are collected by state surveyors no less often than every 15 months. The OSCAR data will supply some of the structural and process measures. These data, however, are collected infrequently and have been subject to disagreement over the accuracy of some of the data elements. Information on facility-level deficiencies is available from OSCAR through the OHCQ.

The MHCC LTCS collects self-reported data from Maryland nursing facilities on an annual basis. As with the OSCAR, the data collected from the LTCS may be used to confer descriptive (structure) and process information.

The MDS will be the source for most QIs in the nursing facility performance evaluation system. The MDS is a subset of the resident assessment instrument (RAI). The RAI is mandated by law to be completed for all nursing facility residents at admission and at regularly scheduled intervals. The MDS portion of the RAI captures the resident's physical and cognitive status, acute medical condition, nutritional status, and behavioral and emotional status. MDS data are routinely submitted by the nursing facility to the state MDS data repository. State data are then transferred into a national repository. Further, MDS data are the only resident level data required from all US nursing homes providing a valuable standardized measurement tool by which to compare facility performance.

Patient Satisfaction

Consumer, or patient, satisfaction is a critical component of measuring the quality of care a facility delivers. Oftentimes, a patient views quality of care as the opinion of the type of treatment he or she received in a nursing facility. For example, did the health care professionals respect the resident's preferences and expressed needs? Did the health care professionals provide emotional support and attempt to alleviate the resident's fears?

Literature reviews indicate that the quality of care provided by a facility is correlated with residents' satisfaction with life in the facility. In addition, studies have shown that in numerous instances those residents with severe cognitive impairment may be labeled incompetent and excluded from satisfaction surveys.[4]

Generally, large multispecialty chain facilities in Maryland conduct resident satisfaction surveys, however, the smaller independent facilities do not. In addition, a national dataset that reports consumer satisfaction measures with nursing facility or other types of long-term care does not exist. However, the national nursing facility trade organizations (e.g., the American Health Care Association, American Association of Homes and Services for

[4] Sandra F. Simmons, John F. Schnelle, Gwen Uman, Alayne Kulvicki, Kyung-Ok Lee, and Joseph Ouslander, "Selecting Nursing Home Residents for Satisfaction Survey," The Gerontologist, (37/4), 1997.

the Aging) do make available instruments for use by their members, and many chain organizations make use of these satisfaction surveys throughout their facilities.

Furthermore, collecting valid and reliable consumer satisfaction data that supplement nursing home based QIs is quite costly. Consumer satisfaction data would add a valuable dimension to the reporting system, but those data are not readily available.

B. Design Issues

Choice of Facilities to Include/Exclude

All comprehensive care nursing home facilities[5] will be considered for inclusion in the performance evaluation report. An issue, however, faced by the Committee was whether to include CCRCs in the report. CCRCs differ from "traditional" nursing facilities because they offer a range of services and housing options on one campus. These communities usually provide independent living, assisted living, and a nursing home component, while some facilities offer single or dual services (such as assisted living and/or independent living). Residents benefit from the flexibility CCRCs offer by providing multiple levels of housing that allows them to move from one setting to another within the facility based on their health care needs.

As charged by the General Assembly during the 1999 legislative session, the MHCC must develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis.[6] The key question posed to the Steering Committee is *should CCRCs be included in the nursing home report card?* The question to consider is whether CCRCs are nursing facilities. Some communities do not offer nursing home services (no comprehensive beds) but offer only independent living and/or assisted living facilities.

The aging population will inevitably create a greater demand for alternative care and housing options to the traditional nursing home care setting. CCRCs have become a alternative to the traditional nursing home; therefore, it may be impractical not to include CCRCs in the report card.

Those CCRC's, however, that do not offer nursing home care are not subject to inspection by the OHCQ state surveyors. Therefore, comparative data would only be relevant for those CCRCs with nursing home beds (twenty-six CCRCs maintain comprehensive beds). Since some CCRCs do offer nursing home services, the Steering

[5] As of October 2000, Maryland had 275 nursing home facilities with 31,073 licensed beds. Licensed nursing home beds are those beds which have received a "comprehensive care facility" (nursing home) license from the OHCQ under COMAR 1-0.07.02.

[6] The purpose of the comparative evaluation system established under this section is to improve the quality of care provided by nursing facilities by establishing a common set of performance measures and disseminating the finding of the comparative evaluation to nursing facilities, consumer, and other interested parties. Assisted living facilities are not considered nursing facilities and therefore, will not be included in the nursing home report.

Committee agreed to include those facilities with comprehensive care beds. The independent living units and assisted living service components of CCRCs would not be presented in the report card.

Another issue was whether facilities with a minimum number of comprehensive care beds should be listed in the guide? The number of comprehensive beds in nursing home facilities and CCRCs varies from zero to 400. The purpose of the performance evaluation system is to improve the quality of care of nursing facilities, therefore not listing the performance measures of facilities with few comprehensive care beds (for example, facilities with less than 20 beds) may not provide a comprehensive assessment of all nursing facilities within Maryland.

However, performance measurement data from comprehensive care facilities with small numbers of nursing home beds may have issues related to small sample sizes. In addition, the lists of information for these small facilities may pose confidentiality problems.

Presentation and Stratification of the Report

The report must be easily understandable and arranged in a logical manner so that the consumer may be able to locate information about a particular facility with minimal difficulty. An issue facing the Steering Committee is how to present the information. Numbers or percentages, graphics, and symbols are examples of how the data may be described. In addition, facilities may be ranked, grouped or benchmarked in order to confer accurate and understandable information to the user. The Committee recognizes the importance of using clear and simple language to confer the nursing facility information.

The report may be stratified according to various formats, such as location of a facility (by regions); case-mix of patients; number of beds; ownership (for-profit vs. non-profit); as well as type of facility (nursing homes vs. CCRCs).

Dissemination (Web-based/Hard-Copy)

How information is presented to the public is important. Web-based technology has enabled some nursing facilities to post information about their specific facility. The Internet has enabled many people to advertise a product to a large number of consumers at a small cost.

A web-based report has many advantages compared to a hard copy version. The cost to publish the data on the Internet is less than printing. Also, the information presented on each facility can be more easily updated. Instead of publishing an annual report, the web will allow the MHCC to update data on a more frequent basis. Moreover, a web-based version will allow consumers to “drill down” so that greater levels of detail can be obtained if the consumer wants this information.

Hard copies of the performance report may reach a greater number of people. A number of Maryland residents currently do not have access to Internet services. In this situation, an alternative may be to distribute a small number of hard copy reports in addition to a general descriptive brochure or to publish the toll free number to the Commission and have the staff download the performance report and mail it to consumers who request it.

The MHCC Health Maintenance Organization (HMO) "report cards" are currently presented in both hard copy and on the Internet, ensuring that the consumer has multiple means of obtaining the information. These HMO reports, however, are only updated on an annual basis.

Audience

When designing a guide, the needs of the audience must be taken into consideration. Consumers may want different information than employers. Hospital discharge planners and insurers, as contractors of nursing facilities, may be interested in more detailed aspects of a nursing facility, whereas the average consumer may be more at ease with general information clearly presented. A nursing facility may want to use the performance evaluation system to help change practice patterns through quality evaluation and improvement or as a competitive marketing tool to show how its services compare with others.

For example, the HMO Guides, distributed by the MHCC, are designed and distributed to a variety of audiences with varied interests and needs for information on the quality of care HMOs provide. The documents range from consumer friendly guides that are easy to understand to complex statistical reports. The following list provides examples of the HMO reports –

The Guide for Consumers is available to those individuals who are contemplating choosing a health plan and employers who are selecting an HMO to offer to their employees.

The Guide for State Employees is a subset of the larger report for consumers designed for the 100,000 State of Maryland employees who are eligible to receive health benefits from the State.

An interactive or web-based version of the report is presented on the MHCC web page. Visitors to the web-based document may choose HMOs that are of interest to them and include the performance information for only those plans in a customized report.

A *Comprehensive Report* was designed for health plans, professional benefit managers, and others who want all the details on how each commercial HMO compares to the others on member ratings and clinical performance (as defined by HEDIS measures). This report is a more complete and statistically detailed, less graphic, compendium of the information that forms the basis of the guide for consumers.

For legislators and policy-makers who want the "big picture" on the strengths and weaknesses of Maryland commercial HMOs, a *Policy Report* is available. The report compares Maryland's commercial HMOs, as a group, to commercial HMOs in the mid-Atlantic region and to HMOs nationally.

IV. Conclusion

The Nursing Home Report Card Steering Committee has reviewed and discussed the key issues outlined above affecting the presentation of performance evaluation data. The Steering Committee has agreed that the nursing facility performance evaluation system should address the following items related to design and content:

Design

1. Information presented to the public should consist of a single performance evaluation report consisting of comprehensive care nursing home facility-level information. CCRCs with comprehensive care beds will also be included in the report.

2. The primary audience for the nursing facility report is the general public residing in Maryland and surrounding states. They consist of both current and future consumers of facilities (both long-term care and sub-acute care residents) and their families/caregivers, in addition to nursing homes, CCRCs, healthcare providers (e.g., hospitals), assisted living facilities, insurers, government entities (e.g., regulators), and the media.

3. The reports should be web-based with supplemental hard-copy brochures describing the report and ways to obtain access. Consumers will access nursing facility specific information from the web site by facility name, geographic region, and through a search capability. In addition, links to relevant web sites will enable the user to obtain additional information on selecting quality nursing facilities.

4. A consumer guide section should also be available on the website to supplement the data. The consumer guide will present the user with additional information to assist in the selection of a nursing facility including issues to consider that are not readily transferable to specific measures of quality. A nursing home checklist should be available either on the report card website or through a link to other existing checklists. A checklist is a questionnaire designed to lead the consumer through the decision making process

Content

5. Structural, or descriptive, and process information is recommended for the initial report – facility characteristics and resident characteristics. These categories contain information determined to be useful for consumers' decision-making processes in selecting a nursing facility and monitoring the quality provided.

   Facility data characteristics will consist of facility descriptive information (e.g., ownership, beds, and fees); licensure and certifications; personnel and staffing; and clinical services (e.g., rehabilitation care, dementia care). The category "resident characteristics" will include information on the gender, age, ethnicity or language,

and functional ability (e.g., percent of residents requiring feeding assistance) of the nursing facility residents.

6. Existing indicators that are valid and reliable should be included as measures of outcomes in the initial report. They would fall under the following domains:

   - Clinical
   - Psychosocial
   - Medication prescribing
   - Functional
   - Satisfaction
   - Quality of life
   - Deficiencies and complaints

   The majority of Quality Indicators (QIs) for the clinical, psychosocial, medication prescribing, and functional domains were developed by the University of Wisconsin Center for Health Services Research and Analysis (CHSRA). The CHSRA indicators have been validated against chart review and subsequently were adopted by HCFA for national use in monitoring nursing facility performance. As required by law, nursing facilities routinely submit MDS data to the state data repository, which is then forwarded to a national repository. QIs are abstracted from the MDS data.

   The Steering Committee agreed to report reliable and valid QIs based on public availability (i.e., only HCFA measures); proprietary measures will not be used. At present, there are few established measures for the satisfaction domain and none for the quality of life domain.

   Nursing facility deficiency and complaint data are reported during the state survey process using the OSCAR database.[7] Complaint data are also collected by the OHCQ and subsequently forwarded to HCFA. The Committee has agreed that valid complaint data should be presented in the report by facility as a rate adjusted for facility size, showing a trend over a three-year period. "Valid" complaints are defined as complaints that have generated a deficiency as defined by federal and state standards.

7. To assure a fair and accurate comparison among the nursing facilities, risk adjustment strategies should be employed whenever possible. While not all QIs require adjusting for patient-level risk, some indicators may necessitate risk-adjustment. This can be achieved though stratification or by regression-based methods. For example, the 'prevalence of stage one to four pressure ulcers' indicator could be adjusted by restricting the denominator to residents without ulcers during the most recent assessment. Another means of risk-adjusting the QIs is by comparing the proportion of residents observed with ulcers to the proportion expected, based on a multivariate regression model that accounts not only for the proportion of residents admitted with

[7] Follow-up surveys may be conducted to assure that facilities correctly identify deficiencies and when a complaint about substandard care is reported.

ulcers but also for other characteristics known to be associated with ulcers (like diabetes and lack of mobility).

8. Patient satisfaction information should not be incorporated in the nursing facility performance evaluation initially. Since nursing facilities do not use a common survey instrument, the Steering Committee concluded that more information is needed in this area. Moreover, surveys currently used by nursing facilities may be designed to address a particular facility's internal needs for quality improvement rather than for public reporting.

   Although Senate Bill 740 (1999) requires the Commission to 'solicit performance information from consumers and families,' consumer information will not be incorporated in the nursing home performance evaluation initially. Budget considerations and time constraints prevent the Commission from conducting a consumer satisfaction survey this year.

9. Because a nursing home administration or a facility's resident characteristics can change rapidly, the report should be updated more often than annually, as feasible.

10. The Maryland Nursing Home Performance Report should be an evolving document incorporating methodological advances in quality reporting over time as new measures are validated. Thus, the Nursing Home Report Card Steering Committee should continue to meet periodically to monitor the progress of report development and consider new measures that have been validated including tools to assess patient satisfaction.

APPENDIX A

Enabling Legislation

SENATE BILL 740 (1999)

Section 19-1508 of the Health General Article

(d) (1) The Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, shall:

(i) On or before July 1, 2001, develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(2) (i) The purpose of the comparative evaluation system established under this section is to improve the quality of care provided by nursing facilities by establishing a common set of performance measures and disseminating the findings of the comparative evaluation to nursing facilities, consumers, and other interested parties.

(ii) In developing the comparative evaluation system, the Commission shall consider the health status of the population served

(3) The system, as appropriate, shall solicit performance information from consumers and their families.

(4) The Commission may adopt regulations to establish the comparative evaluation system provided under this section.

SECTION 3. And be it further enacted, that, on or before January 1, 2001, the Commission shall report to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly on the nursing facility comparative evaluation system required by Section 2 of this Act.

APPENDIX B

Nursing Home Report Card Steering Committee

NURSING HOME REPORT CARD STEERING COMMITTEE

Name	Organization
Barbara McLean, Enrique Martinez-Vidal, Kristin Helfer Koester	Maryland Health Care Commission
Carol Benner, Director or Gene Heisler, Asst Director, Long Term Care Unit	Department of Health and Mental Hygiene, Office of Health Care Quality
Patricia Bayliss State LTC Ombudsman	Department of Aging
Toni Katz LTC Ombudsman	Baltimore City Commission on Aging and Retirement Education
Adam Kane Director of Public Policy and Information	MANPHA
Sister Karen McNally, RSM Administrator	Stella Maris, Inc. (HFAM Representative)
Judith Kasper, Ph.D.	JHU School of Hygiene and Public Health
Meg Johantgen, Ph.D.	University of Maryland School of Nursing
Joan Christian	Family Member of Resident
Nancy Friedley, MD	Director of Clinical Geriatrics University of Maryland Medical System
Frank Chase	United Seniors

APPENDIX C

Examples of Nursing Home Performance Reporting System Web Sites

Organization	State(s)	Web Address	Publication	Data Source(s)	Strengths	Weaknesses	Consumer Guide	# of Drill-downs to a Facility
Health Grades	All	www.healthgrades.com/nhrc	Nursing Home Report Cards	♦ State survey ♦ Panel recommendation regarding severity/ scope/ quality ♦ Patient satisfaction survey (online)	♦ Offers patient satisfaction survey and aggregate results ♦ Provides map and driving directions ♦ Compares facilities within cities (overall score and # of beds) ♦ Consumers can complete a satisfaction survey online for a specific facility	♦ Consumers have to consent to a user agreement to view facility information ♦ Data are from 1998 ♦ Data includes deficiencies only	Checklist/ questions to ask regarding nursing home choice;	4
Health Care Financing Administration	All	www.medicare.gov/NHCompare/Home.asp	Nursing Home Compare	♦ State survey	♦ Provides four topics containing detailed information ♦ Large print ♦ Spanish and Chinese	♦ The consumer has to view the topics in separate screens ♦ There is a lot of descriptive information that may be distracting to consumers	"Guide to choosing a nursing home", also "Nursing Home Checklist", fact sheet, contact list, & Q&As	4
Florida Agency for Health Care Administration (FloridaHealthStat)	FL	www.floridahealthstat.com/publications/Nursguide98/nhguide98.htm	1998 Guide to Nursing Homes in Florida (links to Florida Nursing Home Guide Update - Watch List)	♦ State survey ♦ Quality standards set by state nursing home rating system (minimum standards)	♦ A facility locator ("FacilityStat"), maps directions to a facility from any point of origin	♦ Data are old (1997)	The Guide itself offers questions for consumers to ask NH's	2 (5)

Organization	State(s)	Web Address	Publication	Data Source(s)	Strengths	Weaknesses	Consumer Guide	# of Drill-downs to a Facility
Florida Agency for Health Care Administration	FL	www.fdhc.state.fl.us/Nursing_Home_Guide/index.shtml	Florida Nursing Home Guide Update - Watch List (links to FloridaHealthStat.com's "FacilityStat")	♦ State survey	♦ Provides recent Quarterly info (Jan-Mar 2000) in html and pdf versions	♦ Gives little information on facilities ♦ Reflects those facilities that met the criteria for a conditional status, thus not all facilities are included in the report ♦ Sends the user into an endless search loop		2 (4)
Health Care Financing Administration/Fu Associates	ALL	www.hcfa.fu.com/mdsreports/volume2.asp	MDS Volume Reports	♦ MDS	♦ Begins with resident level information	♦ Data does not include ratings, points or grades for facilities ♦ Primarily for facility administrators and staff		1
New Jersey Department of Health and Senior Services	NJ	www.state.nj.us/health/ltc/hcfa/ www.state.nj.us/health/ltc/penalty	NJ Performance Report for Nursing Homes Also, NJ Nursing Home Inspection Report	♦ State survey ♦ NJ Home inspection Reports including consumer complaints	♦ Provides 2 types of info - facility description - inspection report	♦ Limited information available ♦ Inspection reports do not include all facilities	Comprehensive guide for selecting LTCs by county which compares facilities- includes detailed checklists	2
Massachusetts Department of Public Health – Division of Health Care Quality	MA	www.state.ma.us/dph/qtool/qtind.htm	Nursing Home Survey Tool	♦ State survey ♦ Complaints	♦ Web site offers Consumers comments/ suggestion forms and info request forms	♦ Difficult to understand – very technical	Resource list, detailed question list, & 1- page fact sheet on nursing homes	3
Rhode Island Department of Health - Division of	RI	www.health.state.ri.us/hsr/facreg/facreg.htm	Survey Performance Tool for	♦ State surveys ♦ Complaints	♦ Easy to read ♦ Contact information	♦ Survey data drives quality categories/ score	Resource list, detailed question list, &	2

Organization	State(s)	Web Address	Publication	Data Source(s)	Strengths	Weaknesses	Consumer Guide	# of Drill-downs to a Facility
Facilities Regulation			Nursing Homes		information	♦ Dated survey results	1- page fact sheet on nursing homes	
California Advocates for Nursing Home Reform (CANHR)	CA	www.canhr.org	Data on Nursing Facilities	♦ State survey ♦ CANHR facility questionnaire on services	♦ Organized by county ♦ Provides recent information (less than one year)	♦ Information available is limited to a small number of services and violations ♦ Information is missing or not updated for some facilities ♦ Some links within a county are not active	Detailed checklist, 2 - pg fact sheet, & publication order form on nursing home/LTC topics (most are not free)	3
Texas Department of Human Services	TX	http://www.dhs.state.tx.us/programs/ltc/choosingahome.html	Long Term Care Quality Reporting System (QRS)	♦ State surveys ♦ Unverified resident assessment ♦ Complaints	♦ Visual graphics ♦ Can compare homes within a city	♦ Too much detail regarding methodology ♦ Drilldowns are not consumer oriented	Detailed checklist for selecting LTCs	3
Iowa Department of Inspections and Appeals - Division of Health Facilities	IA	www.dia-hfd.state.ia.us/reportcards	Facility Report Card Search	♦ State survey ♦ Complaint	♦ Data are current (within the past year) ♦ Actual facility surveys are available for viewing/downloading ♦ Consumer friendly search tool	♦ Data are difficult to understand - too technical		2
SeniorCare Resources	All	www.seniorcarehelp.com	Nursing Home Reporter	♦ State survey	♦ Offers "snapshots" and "comprehensive surveys" (made up of 11 detailed reports) on nursing homes ♦ Nursing home inspection data are derived from HCFA	♦ Consumers have to subscribe to the Reporter to access nursing home snapshots: $9.95/day, $14.95/wk,$24.95/mo ♦ Comprehensive surveys are $19.95 per nursing home	HCFA's Nursing Home Compare and "Guide to Choosing a Nursing Home"	
Nursing Home Info	All	www.nursinghomeinfo.com	Facility	♦ Facility –	♦ Consumers can	♦ Facilities are not	Detailed	2

Organization	State(s)	Web Address	Publication	Data Source(s)	Strengths	Weaknesses	Consumer Guide	# of Drill-downs to a Facility
(Nelson & Wallery, Ltd.)			search engine, not a report card system	provided ♦ Other publicly available sources	locate facilities and use interactive map tool	ranked, graded or scored - the only information provided is address and phone #	checklist and fact sheets on selecting nursing homes	
About (The Human Internet)	All	http://alzheimers.about.com/health/alzheimers/cs/nursinghomes/index.htm	Top Nursing Homes by State	♦ Depends on site one links to	♦ Lists nursing facilities with zero deficiencies	♦ No facility data (contact, services, quality, etc)	Good for linking to nursing facilities	
Wisconsin Department of Health & Family Services - Programs & Services	WI	www.dhfs.state.wi.us/bqaconsumer/NursingHomes/CIRindex.htm		♦ State surveys	♦ Detailed facility information that includes staffing data ♦ Mapping capabilities	♦ Links to methods section do not work ♦ No graphics		
Health Care Association of Michigan	MI	www.hcam.org http://hcam.org:591/hcam/default.htm	The Consumer Guide to Nursing Homes	♦ State surveys	♦ Checklists ♦ Consumer input	♦ Unable to access the guide (a connection with the server could not be established)	Several question/check-lists on choosing nursing homes	
Member of the Family, LLC	MD & DC	www.memberofthefamily.net	Nursing Home Report Cards for Maryland & DC	♦ State surveys ♦ Undefined Staffing source ♦ Complaints ♦ Facility provided	♦ Five different topics	♦ Data in each of the topics have to be viewed separately ♦ Data are missing for some facilities ♦ Some topics are difficult to understand - too technical • Incentive to provide information is questionable		5
Senior Alternatives For Living	All	www.senioralternatives.com/nursing.html	Nursing Homes Search by State		♦ Lists features/services offered by facility ♦ Offers "comparative shopping"	♦ Facilities are not ranked, graded or scored	Detailed checklist on selecting nursing homes, Also offers region-specific "guidebooks"; and links to	5

Organization	State(s)	Web Address	Publication	Data Source(s)	Strengths	Weaknesses	Consumer Guide	# of Drill-downs to a Facility
							other sites	
Extended Care Information Network, Inc.	All	www.extendedcare.com	Search for Extended Care Providers	♦ Facility – provided ♦ Other publicly avail-able sources	♦ Search by zip code	♦ Provides basic information on acilities, consumers have to request more information online ♦ Offers CareSearch and CareAssess, but the consumer has to fill out an online request form to get data	Several articles relating to LTC	2
National Eldercare Referral Systems, Inc.	All	www.nursinghomereports.com www.carescout.com	CareScout Ranking/Ratings & Nursing Home Report	♦ Resident-focused inspections ♦ State survey ♦ Voluntary compliance data (JCAHO)	♦ Nursing Home Reports are 7-10 pages and cover quality of care, trends, facility experience levels & historical performance reviews ♦ Rankings and ratings are based on resident-focused inspections	♦ Consumers have to sign in to view CareScout Ratings ♦ Nursing Home Reports are for sale: 1-2=$35; 3-5=$32; 6-8=$29; 9+=$26	CareScout Care Evaluator assists consumers in selecting LTCs; there are many other resources available (mostly for members)	4

APPENDIX D

Policy Paper on Continuing Care Retirement Communities (CCRCs)

Maryland Health Care Commission
Nursing Home Report Card Steering Committee
Continuing Care Retirement Communities (CCRCs)

Background

In recent years, continuing care retirement communities (CCRCs) have emerged as a popular option for retirement living with a long term care component. CCRCs differ from nursing facilities because they offer a range of services and housing options on one campus. These communities usually provide independent living, assisted living, and a nursing home component, while some facilities offer single or dual services (such as assisted living and/or independent living). Residents benefit from the flexibility CCRCs offer by providing multiple levels of housing that allows them to move from one setting to another within the facility based on their health care needs. A barrier to CCRC services is that financing resident placement can be very expensive. Currently, refundable or nonrefundable entry fees for CCRCs in Maryland range from $60,000 to over $400,000 with monthly fees ranging from $700 to $2,500 or more.[8]

CCRCs have been growing in popularity as an increasing number of people search for alternatives to the traditional nursing home. The number of CCRCs grew 50% in the 1980s and continued to grow in the 1990s. In March 2000, 30 CCRCs operated in Maryland with 13, or 45% of the total, located in Baltimore County. Within Maryland, 12 jurisdictions (out of 24) have operating CCRCs.

CCRC contract options are generally classified as Type A, B, or C with each classification based on the services offered by the CCRC and the payment methods.

- Type A communities use an agreement that is considered an *extensive* contract that covers long-term care without any substantial increase in residents' monthly payments.

- Type B communities use a *modified* contract that covers a specified amount of long-term care during a set period of time without a substantial increase in residents' monthly payments.

- Type C communities use a *fee-for-service* contract which covers only basic services that generally are not related to health care. These communities are the least expensive initially, but subsequently require additional add-on charges.

Most of the new CCRCs being developed are Type C communities. Existing CCRCs are attempting to attract new residents by offering a combination of multiple contracts with different pricing arrangements, thus providing additional options. Trends show fewer individuals subscribing to the original CCRC contract (Type A) and instead use Type C, the fee-for-service contract.

In Maryland, the Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ), the Department of Aging,[9] and the Maryland Health Care Commission (MHCC) regulate CCRCs. The Office of Health Care Quality issues licenses for the nursing home component of those facilities with

[8] Continuing Care Retirement Communities: An Examination of Policies Governing the Exemption of Nursing Home Beds from Certificate of Need Review. Final Report. Maryland Health Resources Planning Commission, February 1999.
[9] Article 70B and COMAR 14.11.02

comprehensive care beds. The Department of Aging regulates a CCRC's marketing and contracts. For a CCRC to obtain certification by the Department of Aging, a contract must include the following requirements: 1) subscribers must pay an entrance fee that is, at a minimum, three times the weighted average of the monthly service fees; 2) subscribers must sign a contract for a period of more than one year, usually for life, that requires either a transfer of assets or payment of an entrance fee and monthly fees to live in a secure and protected environment; and, 3) the community must provide, at a minimum, access to medical and nursing services or other health related benefits.

CCRCs' nursing home beds are also regulated under the MHCC's certificate-of-need (CON) program (COMAR 10.24.01) and under planning regulations (COMAR 10.24.08). If a CCRC applies for, and successfully obtains a CON for nursing home beds, it can serve both its own residents as well as the general public. CCRCs, however, can also obtain nursing home beds through a CON exemption (COMAR 10.24.01B(11)(b)(ii)). These beds are known as "waiver beds." An exemption is designed to address the needs of a CCRC that wishes to meet the health care needs of its residents, but does not intend to serve the general public. To qualify for this exemption, a CCRC must satisfy three criteria:

1. Beds obtained through the waiver must not exceed the ratio of one bed for every five independent living units (or 20%);[10]
2. The CCRC must serve exclusively its own residents in the nursing home beds, it cannot admit directly from the general public[11]; and
3. It must provide nursing home care on the same campus as the independent living units.

Future Decisions

As charged by the General Assembly during the 1999 legislative session, the MHCC must develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis.[12] Based on the aforementioned information, the key question posed to the Steering Committee is *should CCRCs be included in the nursing home report card?* The question to consider is whether CCRCs are nursing facilities. Some communities do not offer nursing home services (no comprehensive beds) but offer only independent living and/or assisted living facilities.

The aging population will inevitably create a greater demand for alternative care and housing options to the traditional nursing home care setting. CCRCs have become a variation to the traditional nursing home; therefore, it may be impractical not to include CCRCs in the report card.

[10] This restriction was modified by SB 403 (2000) to 24% for communities with fewer than 300 independent living units.

[11] This restriction was modified during the 2000 Session. Senate Bill 146 (2000) allows a CCRC to directly admit a new resident into the CCRC's nursing facility if the resident pays entrance fees, before entering, that are at least equal to the lowest entrance fee charged for an independent living unit or an assisted living unit. The new resident must, at the time of admission, have the potential for an eventual transfer to an independent living unit or assisted living unit, as determined by the resident's personal physician who is not an owner or employee of the CCRC. The number of residents directly admitted to the nursing facility may not exceed 20 percent of the total number of nursing beds in the facility, and a resident may not be admitted directly if the admission would cause the occupancy of the nursing beds in the CCRC to exceed 95 percent of capacity. The Act terminates on June 30, 2002.

[12] The purpose of the comparative evaluation system established under this section is to improve the quality of care provided by nursing facilities by establishing a common set of performance measures and disseminating the finding of the comparative evaluation to nursing facilities, consumer, and other interested parties.

Those CCRC's, however, that do not offer nursing home care are not subject to inspection by the OHCQ state surveyors. Therefore, comparative data would only be relevant for those CCRCs with nursing home beds. The independent living units and assisted living service components of CCRCs would not be presented in the report card.

In addition, if CCRCs (including nursing homes) are presented in the Report Card *should facilities with a minimum number of comprehensive care beds be listed in the guide?* The number of comprehensive beds in nursing home facilities and CCRCs varies from zero to 400. The purpose of the Report Card is to improve the quality of care of nursing facilities, therefore not listing the performance measures of facilities with few nursing home beds (for example, facilities with less than 20 beds) may not provide a comprehensive assessment of all nursing facilities within Maryland.

However, performance measurement data from facilities with small numbers of nursing home beds may have issues related to small sample sizes. In addition, the lists of information for these small facilities may pose confidentiality problems.

CCRCs with CON Comprehensive-Care Beds

	Name	Location	Number of COMP beds (in ascending order)
1.	Presbyterian Home	Baltimore County	22
2.	Baptist Home	Baltimore County	23
3.	William Hill Manor	Talbot	24
4.	Collington	Prince George's	44
5.	Pickersgill Inc.	Baltimore County	60
6.	Roland Park Place	Baltimore City	71
7.	Edenwald	Baltimore County	72
8.	Fairhaven	Carroll	72
9.	Wesley Home	Baltimore City	75
10.	Broadmead	Baltimore County	79
11.	Maryland Masonic Homes	Baltimore County	130
13.	Asbury Methodist Village	Montgomery	285
14.	National Lutheran Home	Montgomery	300
12.	Augsburg Lutheran Home/ Augsburg Lutheran Village *	Baltimore County	155/0

* Augsburg Lutheran Village and Augsburg Lutheran Home are two separate legal entities sharing a single CCRC campus.
Note: Some CCRCs were "grandfathered" because they existed prior to the establishment of the CON program.

CCRCs with CON-exempt Comprehensive-Care Beds			
	Name	**Location**	**Number of COMP beds (in ascending order)**
1.	Maplewood Park Place*	Montgomery	28
2.	Glen Meadows	Baltimore County	31
3.	Heron Pt. of Chestertown	Kent	36
4.	North Oaks	Baltimore County	37
5.	Buckingham's Choice	Frederick	41
6.	Asbury-Solomons Island	Calvert	42
7.	Vantage House	Howard	44
8.	Blakehurst	Baltimore County	54
9.	Ginger Cove**	Anne Arundel	55
10.	Bedford Court*	Montgomery	60
11.	Oak Crest Village	Baltimore County	240
12.	Charlestown	Baltimore County	270

* Includes leased CON beds

** Includes dually licensed beds (both CON and CON-exempt)

CCRCs without Comprehensive-Care Beds		
	Name	**Location**
1.	Carroll Lutheran Village	Carroll
2.	Church Home	Baltimore City
3.	Frederick Home	Frederick
4.	Homewood	Washington

MHRPC Inventory of Comprehensive Care Beds (September 1999)					
Region	**County**	**Licensed Beds**	**Certified Beds (CON approved)**	**Waiver Beds (CON exempt)**	**Total Beds**
Baltimore Metro. Area	Baltimore City	6298	263	111	6672
	Baltimore County	6041	27	169	6237
	Harford County	657	40	139	836
	Howard County	524	82	10	616
	Anne Arundel County	1700	93	90	1883
	TOTAL	**15,220**	**505**	**519**	**16,224**
Eastern & Southern MD	St. Mary's County	337	0	0	337
	Charles County	377	0	0	377
	Calvert County	294	0	0	294
	Cecil County	446	9	10	465
	Kent County	204	0	2	206
	Queen Anne's County	180	0	0	180
	Talbot County	358	0	0	358
	Caroline County	237	0	0	237
	Dorchester County	313	10	0	323
	Wicomico County	742	37	0	779
	Somerset County	210	0	3	213
	Worcester County	376	2	0	378
	TOTAL	**4074**	**58**	**15**	**4147**
Washington, DC Metro. Area	Montgomery County	4816	12	83	4911
	Prince George's County	2858	230	42	3130
	TOTAL	**7674**	**242**	**125**	**8041**
Western MD	Garrett County	344	0	0	344
	Allegheny County	931	18	19	968
	Washington County	1293	0	6	1299
	Carroll County	811	138	14	963
	Frederick County	1043	0	10	1053
	TOTAL	**4422**	**156**	**49**	**4627**
Maryland State Total (9/99)		31,390	961	708	33,059

NOTES:

The State Health Plan chapter governing review and approval of long term care services, COMAR 10.24.08, permits the Commission to docket for review a CON application to establish or expand a nursing facility only if the bed need projection currently in effect shows unmet need for new beds in the jurisdiction in question.

The analysis of applications for CON approval for new or expanded nursing homes includes an evaluation of how the proposed project meets the applicable standards, policies, and need projections in the State Health Plan, and how it addresses the six general review criteria found in the CON procedural regulations at COMAR 10.24.01.08G(3). The other element of CON review, the currently-applicable bed need projection, is derived through a set of assumptions about the State's available inventory of nursing home beds and about the use rates and origin of nursing home patients in different age groups, applied to population and demographics.

Waiver beds, approved under COMAR 10.24.01.02 (A)(2)a, involve an increase in bed capacity of ten beds or ten percent of the facility's total capacity, whichever is less.

APPENDIX E

Recommended Quality Measures to be Included in Performance Report

III. Quality Measures*	*** Note: Only currently available and validated quality indicators were considered. Proprietary measures were excluded. HCFA currently is developing a new set of indicators. A draft version of these indicators is listed at (www.abt-tech.com/qidoc); until Nov 15th 2000, however, none of these indicators have been validated nor are they ready for use.**		**Note: The current HCFA measures apply to the long-term care population. They exclude all admission, readmission and all Medicare 5, 14, 30, 60-day MDS assessments. Currently based on quarterly and annual assessments.**	
III-A. Clinical measures				
i. Falls	a. Incidence of new fractures (HCFA)[1]	a. MDS 2.0	**Numerator:** Residents with new fractures on most recent assessment. *MOST RECENT ASSESSMENT:* New hip fracture (J4c is checked on most recent assessment and J4c is not checked on previous assessment) OR Other new fractures (J4d is checked on most recent assessment and J4d is not checked on previous assessment) **Denominator:** Residents who did not have fractures on the previous assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	b. Prevalence of falls (HCFA)[1]	b. MDS 2.0	***Numerator:*** *Residents who had falls on most recent assessment.* *MOST RECENT ASSESSMENT:* Fall within past 30 days (J4a is checked) **Denominator:** All residents on most recent assessment. **NO RISK ADJUSTMENT**	1. Select time frame to define total denominator population of residents for measure.

ii. Pressure ulcers	a. Prevalence of stage 1-4 pressure ulcers (HCFA) [1]	a. MDS 2.0	***Numerator:*** *Residents with pressure ulcers (Stage 1 – 4) on most recent assessment.* *MOST RECENT ASSESSMENT:* Pressure ulcer (M2a›0, or I3=ICD-9 CM 707.0)[2] **Denominator:** All residents on most recent assessment. **HIGH RISK:** *Impaired transfer or bed mobility (G1a or b=3 or 4- Box A),* *OR comatose (B1=1), OR malnutrition (I3=ICD-9 CM 260, or 261, or 262, or 263.0, or 263.1, or 263.2, or 263.8, or 263.9)[2] OR end stage disease (J5c is checked) MOST RECENT ASSESSMENT.* ***LOW RISK:*** All others at MOST RECENT ASSESSMENT.	1. Select time frame to define total denominator population of residents for measure.
iii. Incontinence	a. Prevalence of bladder or bowel incontinence (HCFA)[1]	a. MDS 2.0	***Numerator:*** *Residents who were frequently incontinent or incontinent on most recent assessment.* *MOST RECENT ASSESSMENT:* Bladder Incontinence (H1b=3 or 4); OR Bowel Incontinence (H1a=3 or 4). **Denominator:** All residents, except as noted in exclusion. *EXCLUDE: Residents who are Comatose (B1=1); OR have indwelling catheter (H3d is checked); OR have an ostomy (H3i is checked) at MOST RECENT ASSESSMENT.* **HIGH RISK:** *Severe cognitive impairment (see Glossary); OR totally ADL dependent in mobility ADL's (G1 a, b, e-Box A self-performance = 4 in all areas) at MOST RECENT ASSESSMENT.* ***LOW RISK*:** *All others at MOST RECENT ASSESSMENT.*	1. Select time frame to define total denominator population of residents for measure.

	b. Prevalence incontinence without a toileting plan (HCFA)[1]	b. MDS 2.0	**Numerator:** Residents without toileting plan on most recent assessment. *MOST RECENT ASSESSMENT:* No scheduled toileting plan and no bladder retraining program. (Neither H3a nor H3b is checked) **Denominator:** Residents with frequent incontinence or occasionally incontinent in either bladder or bowel on most recent assessment. *MOST RECENT ASSESSMENT:* Occasional or frequent bladder incontinence (H1b =2 or 3) OR bowel incontinence (H1a=2 or 3). ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure
	c. Prevalence of indwelling catheters (HCFA) [1]	c. MDS 2.0	**Numerator:** Indwelling catheter on most recent assessment. *MOST RECENT ASSESSMENT:* Indwelling catheter (H3d is checked). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	d. Prevalence of fecal impaction (HCFA) [1]	d. MDS 2.0	**Numerator:** Residents with fecal impaction on most recent assessment. *MOST RECENT ASSESSMENT:* Fecal impaction (H2d is checked). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
iii. Pain	a. Prevalence of pain (CHSRA)	a. Non-HCFA measure developed by Zimmerman. Uses quarterly MDS assessments to calculate prevalence of pain.	**Numerator:** Residents with moderate or excruciating pain less than daily or mild, >moderate, or excruciating pain daily on most recent assessment pain on most recent assessment. *MOST RECENT ASSESSMENT* Pain (J2a = 1 and J2b = 2 or 3 OR J2a = 2 and J2b = 1, 2, or 3) **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

iv. Nutrition	a. Prevalence of weight loss (HCFA) [1]	a. MDS 2.0	**Numerator:** Proportion of residents with weight loss of 5% or more in the last 30 days or 10% or more in the last 6 months on most recent assessment. *MOST RECENT ASSESSMENT:* Weight loss (K3a=1). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	b. Prevalence of tube feeding (HCFA) [1]	b. MDS 2.0	**Numerator:** Residents with tube feeding on most recent assessment. *MOST RECENT ASSESSMENT:* Feeding tube (K5b is checked). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	c. Prevalence of Dehydration (HCFA) [1]	c. MDS 2.0	**Numerator:** Residents with tube feeding on most recent assessment. *MOST RECENT ASSESSMENT:* Dehydration – output exceeds input (J1c is checked or I3=ICD 9 CM 276.5)[1] **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
v. Infections	a. Prevalence of urinary tract infections (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents with urinary tract infections on most recent assessment. *MOST RECENT ASSESSMENT:* Urinary tract infection (I2j is checked). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
vi. Restraints	a. Prevalence of daily physical restraints (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents who were physically restrained daily on most recent assessment. *MOST RECENT ASSESSMENT:* Daily physical restraints (P4c or d or e = 2). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

III-B. Psychosocial				
i. Behavior	a. Prevalence of behavioral symptoms affecting others (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents with behavioral symptoms affection others on most recent assessment. *MOST RECENT ASSESSMENT:* Behavioral symptoms affecting others: Verbally abusive (E4b-Box A›0); OR physically abusive (E4c-Box A›0); OR socially inappropriate/ disruptive behavior (E4d-Box A›0). **Denominator:** All residents on most recent assessment. ***HIGH RISK:*** [Presence of Cognitive Impairment (see Glossary)] ON THE MOST RECENT ASSESSMENT. OR [Psychotic disorders (I3=ICD 9 CM 295.00-295.9; 297.00-298.9 or I1gg schizophrenia is checked)] OR [Manic-depressive (I3=ICD 9 CM 296.00-296.9 or I1ff is checked)][2] at the MOST RECENT OR ON THE MOST RECENT FULL ASSESSMENT. ***LOW RISK:*** All others at MOST RECENT ASSESSMENT. Note: When the most recent assessment is a Quarterly Assessment, we will "carry forward" information about psychotic disorders and manic depression from the most recent **FULL** assessment.	1. Select time frame to define total denominator population of residents for measure.
ii. Dementia	a. Incidence of cognitive impairment (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents who were newly cognitively impaired on most recent assessment. *MOST RECENT ASSESSMENT:* Cognitively impaired. **Denominator:** Residents who were not cognitively impaired on previous assessment. *PREVIOUS ASSESSMENT:* Does not have cognitive impairment. For definition of cognitive impairment, see Glossary. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

iii. Depression	a. Prevalence of symptoms of depression (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents with Symptoms of depression on most recent assessment. *MOST RECENT ASSESSMENT:* Sad mood (E2=1 or 2) and [at least 2 symptoms of functional depression]; *Symptoms of functional depression:* *Symptom 1: distress (E1a=1or2- resident made negative statements);* *Symptom 2: agitation or withdrawal (E1n=1or2-repetitive physical movements), or (E4e-Box A=1, 2, or 3-resists care), or (E1o=1or2-withdrawal from activity), or (E1p=1or2-reduced social activity);* *Symptom 3: wake with unpleasant mood (E1j=1or 2), or not awake most of the day (N1d is checked), or awake 1 period of the day or less and not comatose (N1a+N1b+N1c<1 and B1=0);* *Symptom 4: suicidal or has recurrent thoughts of death (E1g=1or2);* *Symptom 5: weight loss (K3a=1).* **Denominator:** All residents on the most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	b. Prevalence of symptoms of depression w/o antidepressant therapy (HCFA) [1]	b. MDS 2.0	**Numerator:** Residents with symptoms of depression on most recent assessment and no antidepressant therapy. MOST RECENT ASSESSMENT: Depression and no antidepressant (O4c=0) **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

III-C. Medication Prescribing				
i. Anti-Psychotic medications	a. Prevalence of antianxiety/hypnotic use (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents who received antianxiety or hypnotics on most recent assessment. *MOST RECENT ASSESSMENT:* Antianxiety/hypnotic (O4b or O4d ›1). **Denominator:** All residents on most recent assessment, except those with psychotic or related conditions (see exclusion). Exclusions: Residents with one of more psychotic disorders (I3 = 295.00 – 295.9; 297.00-298.0) or I1gg schizophrenia is checked) OR Tourette's (I3=307.23) OR Huntingtons' (I3-333.4) on the most recent or on the most recent full assessment; of with hallucinations (j1I is checked) on the most recent assessment. Note: when most recent assessment is a quarterly, information about psychotic disorders, Tourettes, and Hungtington's from the most recent full assessment will be carried forward. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	b. Prevalence of hypnotic use more that two times in last week (HCFA) [1]	b. MDS 2.0	**Numerator:** Residents who received hypnotics more than 2 times in last week on most recent assessment. *MOST RECENT ASSESSMENT:* Hypnotic drug use more than 2 of the last 7 days (O4d ›2) **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

	c. Prevalence of antipsychotics use in the absence of psychotic and related conditions.(HCFA) [1]	c. MDS 2.0	**Numerator:** Residents receiving anti-psychotics on most recent assessment. *MOST RECENT ASSESSMENT:* Antipsychotics (O4a ≥ 1). **Denominator:** All residents on most recent assessment, except those with psychotic or related conditions (see exclusion below). EXCLUDE: Residents with one or more psychotic disorders (I3=295.00-295.9; 297.00-298.9); or I1gg schizophrenia is checked) OR Tourette's (I3=307.23); OR Huntington's (I3=333.4)[2] ON THE MOST RECENT OR ON THE MOST RECENT FULL ASSESSMENT; OR with hallucinations (J1i is checked) ON THE MOST RECENT ASSESSMENT Note: When the most recent assessment is a Quarterly Assessment, we will carry forward information about psychotic disorders, Tourette's, and Huntington's from the most recent **full** assessment. ***HIGH RISK:*** Cognitive impairment AND behavior problems at MOST RECENT ASSESSMENT. (see Glossary for definitions). ***LOW RISK:*** All others at MOST RECENT ASSESSMENT.	1. Select time frame to define total denominator population of residents for measure.

III-D. Functional measures				
i. Activity of Daily Living (ADL) function	a. Incidence of decline in late loss ADLs (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents showing ADL decline in self-performance between previous and most recent assessment. a. One level decline in two or more late loss ADL's OR b. Two-level decline in one or more late loss ADL's. At least a ONE level decline in TWO or more of the following: bed mobility, transfer, eating, toileting. G1 a, b, h, I coding pattern Box A: Previous Assessment / Most Recent Assessment 0 — 1,2,3, or 4 1 — 2,3, or 4 2 — 3 or 4 3 — 4 OR At least a TWO level decline in ONE or more of the following: bed mobility, transfer, eating, toileting G1 a, b, h, I coding pattern Box A: Previous Assessment / Most Recent Assessment 0 — 2,3,4 1 — 3,4 2 — 4 Note: A value of 8 is equal to missing for purposes of defining the change in ADL. **Denominator:** All residents who are totally dependent on ADL. (G1a-j Box A –all items=4 or 8) OR comatose (B1=1) on PREVIOUS ASSESSMENT. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.

	b. Incidence of decline in range of motion (ROM) (HCFA) [1]	b. MDS 2.0	**Numerator:** Residents with increases in functional limitation in ROM (G4a-f-BoxA›0) in most recent assessment is greater than the functional limitation in ROM on the Previous Assessment. Most Recent Assessment [SUM G4a-f] ↑ Box A › Previous Assessment [SUM G4a-f] ↑ Box A **Denominator:** All residents with previous and most recent assessments, with the exclusion noted. EXCLUDE: Residents with maximal loss of ROM at previous assessment (Sum G4a-f, Box A, is 12 on previous assessment). ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
ii. Activity level	a. Prevalence of bedfast residents (HCFA) [1]	a. MDS 2.0	**Numerator:** Residents who are bedfast on most recent assessment. *MOST RECENT ASSESSMENT:* Bedfast (G6a is checked). **Denominator:** All residents on most recent assessment. ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
	b. Prevalence of little of no activity (HCFA) [1]	b. MDS 2.0	**Numerator:** Residents with little or no activity on most recent assessment. *MOST RECENT ASSESSMENT:* Little or no activity (N2=2 or 3). **Denominator:** All residents (except comatose) on most recent assessment. EXCLUDE: Residents who are comatose (B1=1). ***NO RISK ADJUSTMENT***	1. Select time frame to define total denominator population of residents for measure.
III-E. Satisfaction				
Under consideration	Further investigation warranted. Currently, no standardized, validated measure has been developed for long-term or post-acute care population.			

III-F. Quality of Life				
Under consideration	Further investigation warranted. Currently, no standardized, validated measure has been developed for long-term or post-acute care population.			
C. III-G. Deficiencies, Complaints and Compliance				
i. Complaints	a. Number complaints per year adjusted for facility size.	a. DOH complaint data & MD LTCS, & OSCAR.	a. Number of complaints registered in last calendar year adjust by number of residents. Number of residents equals number of admissions in past calendar year (MD LTCS Q17) plus an estimate of the number of residents in the facility as of Jan 1 (estimate using total beds multiplied by occupancy rate).	1. Need to determine status of complaint data files in MD.
ii. Deficiencies on Survey	a. Total # deficiencies on past survey b. # Deficiencies by severity c. # Deficiencies by category	a. OSCAR b. OSCAR c. OSCAR	a. Total # any deficiency b. Report total number in each severity class • Potential for Minimal Harm = 1 • Minimal Harm or Potential for Actual Harm = 2 • Actual Harm = 3 • Immediate Jeopardy = 4 c. Report total number in each category Survey Performance Score - aggregates survey score in five categories: • administration, • nursing, • resident rights, • kitchen/food service, • environment	1. a.-c. Need to provide date of last OSCAR survey 2. a.-c. Group by facility size or other facility characteristics

	d. Trend deficiency data over past 3 reports (past ~3-4 yrs). • Average Number of deficiencies in past XX years.	d. OSCAR	d. Trend data can be presented as • average over past 3 OSCAR report • numbers for each of last 3 reports	1. Group by facility size or other facility characteristics.
iii. Compliance	Compliance by deficiency category.	e. OSCAR	**Numerator:** Number corrected deficiencies from previous survey. **Denominator:** Number deficiencies originally cited in previous survey.	1. Annual

Footnotes Related to Quality Measures:

1. HCFA measures were developed by Center for Health Systems Research and Analysis at Univ. of Wisconsin by David Zimmerman. Most require only one MDS assessment (except for incidence measures that require two MDS assessments). CHSRA QIs apply to the long term population only and were not developed for short term residents (e.g. subacute) and utilize quarterly or annual MDS assessments (e.g. exclude admission and readmission assessments).